General Assembly **Amendment**

January Session, 2009 LCO No. **8506**

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Offered by:
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To: Subst. Senate Bill No. **47** File No. 176 Cal. No. 201

"AN ACT CONCERNING HEALTH CARE PROVIDER CONTRACTS."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. Section 38a-479 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

(a) As used in this section and section 2 of this act:

(1) "Contracting health organization" means **[**(A)**]** a managed care organization, as defined in section 38a-478, or **[**(B)**]** a preferred provider network, as defined in section 38a-479aa. **[**; and (2) "physician" means a physician or surgeon, chiropractor, podiatrist, psychologist or optometrist.**]**

(2) "Provider" means a physician, surgeon, chiropractor, podiatrist, psychologist, optometrist, natureopath or advanced practice registered

nurse licensed in this state or a group or organization of such individuals, who has entered into or renews a participating provider contract with a contracting health organization to render services to such organization's enrollees and enrollee's dependents.

(b) **[**Not later than October 1, 2007, each**]** Each contracting health organization shall establish and implement a procedure **[**reasonably designed to permit a physician, physician group or physician organization under contract with such contracting health organization to view, on a confidential basis, in a**]** to provide to each provider:

(1) Access via the Internet or other electronic or digital format **[**or by electronic means, at the option of such organization, the fee-for-service dollar amount such organization reimburses pursuant to the organization's contract with the physician, physician group or physician organization for the fifty current procedural terminology codes most commonly performed by the physician, physician group or physician organization**]** to the contracting health organization's fees for (A) the current procedural terminology (CPT) codes applicable to such provider's specialty, (B) the Health Care Procedure Coding System (HCPCS) codes applicable to such provider, and (C) such CPT codes and HCPCS codes as may be requested by such provider for other services such provider actually bills or intends to bill the contracting health organization, provided such codes are within the provider's specialty or subspecialty; and

(2) Access via the Internet or other electronic or digital format to the contracting health organization's policies and procedures regarding (A) payments to providers, (B) providers' duties and requirements under the participating provider contract, (C) inquiries and appeals from providers, including contact information for the office or offices responsible for responding to such inquiries or appeals and a description of the rights of a provider, enrollee and enrollee's dependents with respect to an appeal.

[(c) The procedure established by a contracting health organization

shall also permit a physician, physician group or physician organization to request and view fee-for-service dollar amounts the contracting health organization reimburses for current procedural terminology codes for which a physician, physician group or physician organization actually bills or intends to bill the contracting health organization, provided such codes are within the physician's, group's or organization's specialty or subspecialty.**]**

[(d)**]** (c) The provisions of **[**subsections (b) and (c)**]** subdivision (1) of subsection (b) of this section shall not apply to any **[**physician, physician group or physician organization**]** provider whose services are reimbursed in a manner that does not utilize current procedural terminology codes.

[(e)**]** (d) The fee information received by a **[**physician, physician group or physician organization**]** provider pursuant to subdivision (1) of subsection (b) of this section is proprietary and shall be confidential, and the procedure adopted pursuant to this section may contain penalties for the unauthorized distribution of fee information, which may include termination **[**from the contracting health organization network**]** of the participating provider contract.

Sec. 2. (NEW) (*Effective July 1, 2010*) (a) No contracting health organization shall make material changes to a provider's fee schedule except as follows:

(1) At one time annually, provided providers are given at least ninety days' advance notice by mail, electronic mail or facsimile by such organization of any such changes. Upon receipt of such notice, a provider may terminate the participating provider contract with at least sixty days' advance written notice to the contracting health organization;

(2) At any time for the following, provided providers are given at least thirty days' advance notice by mail, electronic mail or facsimile by such organization of any such changes:

(A) To comply with requirements of federal or state law, regulation or policy. If such federal or state law, regulation or policy takes effect in less than thirty days, the organization shall give providers as much notice as possible;

(B) To comply with changes to the medical data code sets set forth in 45 CFR 162.1002, as amended from time to time;

(C) To comply with changes to national best practice protocols made by the National Quality Forum or other national accrediting or standard-setting organization based on peer-reviewed medical literature generally recognized by the relevant medical community or the results of clinical trials generally recognized and accepted by the relevant medical community;

(D) To be consistent with changes made in Medicare pertaining to billing or medical management practices, provided any such changes are applied to relevant participating provider contracts where such changes pertain to the same specialty or payment methodology;

(E) If a drug, treatment, procedure or device is identified as no longer safe and effective by the federal Food and Drug Administration or by peer-reviewed medical literature generally recognized by the relevant medical community;

(F) To address payment or reimbursement for a new drug, treatment, procedure or device that becomes available and is determined to be safe and effective by the federal Food and Drug Administration or by peer-reviewed medical literature generally recognized by the relevant medical community; or

(G) As mutually agreed to by the contracting health organization and the provider. If the contracting health organization and the provider do not mutually agree, the provider's current fee schedule shall remain in force until the annual change permitted pursuant to subdivision (1) of this subsection.

(b) (1) No contracting health organization shall cancel, deny or demand the return of full or partial payment for an authorized covered service due to administrative or eligibility error, more than eighteen months after the date of the receipt of a clean claim, except if:

(A) Such organization has a documented basis to believe that such claim was submitted fraudulently by such provider;

(B) The provider did not bill appropriately for such claim based on the documentation or evidence of what medical service was actually provided;

(C) Such organization has paid the provider for such claim more than once;

(D) Such organization paid a claim that should have been or was paid by a federal or state program; or

(E) The provider received payment for such claim from a different insurer, payor or administrator through coordination of benefits or subrogation, or due to coverage under an automobile insurance or workers' compensation policy. Such provider shall have one year after the date of the cancellation, denial or return of full or partial payment to resubmit an adjusted secondary payor claim with such organization on a secondary payor basis, regardless of such organization's timely filing requirements.

(2) (A) Such organization shall give at least thirty days' advance notice to a provider by mail, electronic mail or facsimile of the organization's cancellation, denial or demand for the return of full or partial payment pursuant to subdivision (1) of this subsection.

(B) If such organization demands the return of full or partial payment from a provider, the notice required under subparagraph (A) of this subdivision shall disclose to the provider (i) the amount that is demanded to be returned, (ii) the claim that is the subject of such demand, and (iii) the basis on which such return is being demanded.

(C) Not later than thirty days after the receipt of the notice required under subparagraph (A) of this subdivision, a provider may appeal such cancellation, denial or demand in accordance with the procedures provided by such organization. Any demand for the return of full or partial payment shall be stayed during the pendency of such appeal.

(D) If there is no appeal or an appeal is denied, such provider may resubmit an adjusted claim, if applicable, to such organization, not later than thirty days after the receipt of the notice required under subparagraph (A) of this subdivision or the denial of the appeal, whichever is applicable, except that if a return of payment was demanded pursuant to subparagraph (C) of subdivision (1) of this subsection, such claim shall not be resubmitted.

(E) A provider shall have one year after the date of the written notice set forth in subparagraph (A) of this subdivision to identify any other appropriate insurance coverage applicable on the date of service and to file a claim with such insurer, health care center or other issuing entity, regardless of such insurer's, health care center's or other issuing entity's timely filing requirements."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2010*	38a-479
Sec. 2	*July 1, 2010*	New section